Einstein
Advanced Health Insurance Solutions

NEWSALERT

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ACA Compliance

IRS Issues 30,000 Employer Mandate Penalty Notices

THE IRS has been sending penalty notices to more than 30,000 businesses nationwide, advising them that they may be out of compliance with the Affordable Care Act employer mandate.

The tax agency said those employers are on the hook for a total of roughly $4.3 billion in fines.

While the individual mandate has been repealed starting in 2019, the employer mandate is intact and the IRS is pursuing penalties aggressively.

Under the ACA, companies with more than 50 full-time employees are required to extend health insurance to their workers. Failure to do so can result in penalties as high as $2,000 per worker.

As the IRS steps up its efforts to pursue companies that fail to comply with the employer mandate, a report in the *New York Times* indicates that many of the letters that were sent out were for clerical errors that the employer can address in order to avoid the fine.

The Congressional Budget Office predicts the IRS could levy $12 billion in employer mandate violation fines in 2018.

And the IRS is just getting started. It had to put off enforcement of the employer mandate for the first year it was in effect, 2014, because of delays in reporting and the Treasury Department clarifying the requirements.

That means the first round of penalty notices that are being sent out now are only for the 2015 tax year. Once it's done sending those out, pundits say that the IRS will quickly start sending out penalty notifications for 2016 and 2017.

The *New York Times* reported that the IRS is working with some businesses that experienced technical or paperwork issues to help them avoid fines.

E. Neil Trautwein, vice president at the National Retail Federation, told the newspaper that some employers are receiving notifications because they checked the wrong box on their 1094-C forms.

Employee benefits attorney John D. Arendshorst told the paper that the government has shown a willingness to reduce penalties when appropriate.

He cited one case where a business with some 500 employees had been notified that it faced a $1.9 million fine, which was eventually reduced to $20,000 because the penalty had been caused by a computer error.

If you get a letter

When notifying an employer of a fine, the IRS uses Letter 226-J. The most likely cause of incorrect assessments is errors in

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Advanced Health Insurance Solutions

CONTACT US

Missouri: **4359 Forest Park Avenue, St. Louis, MO 63108**
Illinois: **280 North Main Street, Breese, IL 62230**

Phone: 877.324.2114
Fax: 888.274.1538
Email: *info@ecgins.com*

Voluntary Benefits

HSA Contribution, HDHP Deductible Limits Set for 2019

THE IRS has increased health savings account contribution limits for 2019, along with changes to the out-of-pocket expenses for HSA-qualifying high-deductible health plans (HDHPs).

Maximum contribution changes

HSA type	2018	2019
Individual coverage	$3,450	$3,500
Family coverage	$6,900	$7,000

Individuals age 55 or older not yet enrolled in Medicare may make a catch-up HSA contribution of up to $1,000 – an amount that remains unchanged from last year's catch-up limit.

This most recent set of limit adjustments fits the pattern of previous years, with the IRS announcing HSA limits in early May for the following tax year and generally leaving those limits unchanged throughout the tax year.

However, this year the IRS made a surprise announcement that it had reduced the 2018 maximum family contribution to an HSA from $6,900 to $6,850. (Individual contribution limits weren't impacted at the time.)

It was forced to make the change due to a provision in the tax reform law that changed the way that inflation-related increases are calculated from the Consumer Price Index.

It also announced in April that it would allow taxpayers to treat the 2018 HSA contribution limit for an individual with family coverage under a HDHP as $6,900.

HDHP deductibles and out-of-pocket maximums

The minimum deductibles for HSA-qualified HDHPs are unchanged for 2019: $1,350 for individual coverage, and $2,700 for family coverage.

But, the 2019 out-of-pocket maximums for HDHPs were increased to $6,750 for individual coverage and $13,500 for family coverage, from $6,650 and $13,300 respectively this year.

The increases for HDHP out-of-pocket maximums allow plan sponsors more flexibility when determining potential deductibles. They also factor into the decision-making process for account holders when determining how much to contribute to their HSA. ❖

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Be Sure to Analyze the Letter for Accuracy

Forms 1094-C and 1095-C. If you receive a letter, consulting firm Towers Watson recommends that you:

- **Respond within 30 days or request an extension.** Unless the IRS receives a response within 30 days, the agency will assume that its facts and penalty amount are correct. Employers can request an extension by calling the phone number at the top of the Employer Shared Responsibility Payment (ESRP) Response form. The IRS typically grants these requests.
- **Analyze the letter for accuracy.** Review all documents you filed with the IRS and provided to employees to ensure that the information on them is correct and that they match the information in the IRS letter. The review should include the following:
  - Ensure that all employees listed in the letter as receiving a premium tax credit were common-law employees.
  - Check whether any employees listed as having received a premium tax credit were enrolled in your health plan.
  - Check whether you offered health coverage to employees who were not enrolled in the health plan and who received a premium tax credit.
  - Verify that all employees listed as receiving a premium tax credit were full-time staff.
- **Decide whether to challenge the assessment.** If you feel there is a discrepancy between your numbers and those provided by the IRS, you should fill out the ESRP Response form. This filing should include a signed statement explaining the reason(s) for the disagreement and any supporting documentation. ❖

Pharmaceutical Costs

Skyrocketing Drug Prices Threaten Health Insurance Model

THE U.S. is experiencing a prescription drug pricing epidemic, and some drug companies are driving a wedge into the health insurance model by severely jacking up pharmaceutical prices to astronomical levels.

Unfortunately, the cost of some drugs has become so extreme that by paying for one prescription it could take decades to recoup the cost in premium collections.

The scourge was recently highlighted in an investigative report by "60 Minutes" on CBS.

The investigation reflects the difficulties facing health insurers in paying for drugs and also the fact that many pharmacy benefit managers, which are in business to rein in runaway drug costs, are not actually doing much to stem the rampant and exorbitant price increases.

The "60 Minutes" piece focused on one city which was faced with financial ruin because of the costs of just one drug for one of its employees. The city's experience is emblematic of just how bad things have gotten.

The city of Rockford, Ill., had for years been self-insuring and paying the health care costs for its 1,000 employees and their dependents. But then one pharmaceutical busted the city's health care budget: Acthar.

In 2015, two small children of Rockford employees were treated with Acthar, a drug that's been on the market since 1952. It is used to treat a rare and potentially fatal condition called infantile spasms, which afflicts about 2,000 babies a year.

The drug had been affordable in 2001 when it sold for about $40 a vial. By 2015, the price had spiraled to $40,000 a vial – a phenomenal 100,000% increase.

As a result, the city paid out close to $500,000 for the two children's Acthar prescriptions.

The problem is that Acthar is not the only drug on the market that has seen that kind of price increase. Pharmaceutical companies have been on a major price-hike spree, pushing once-affordable drugs into the stratosphere – often after one company buys the rights to a drug from another firm.

The maker of Acthar also in 2010 decided that it wanted to boost sales of the drug because there are only about 2,000 cases of infantile spasms a year. So it started marketing it to doctors for other diseases that it was not designed to treat.

The company began to market the drug for several chronic conditions like rheumatoid arthritis that affect adults, even though there was no evidence it worked for these conditions.

Prescriptions surged, and by 2015 Medicare was spending $500 million a year on Acthar.

People were able to get those prescriptions because many of the doctors who prescribed a lot of Acthar also were getting money from the company. The drugmaker paid them for speaking, consulting and conducting research studies for the company.

"60 Minutes" found that those doctors appear to be the ones who are most likely to also prescribe Acthar. The drugmaker paid doctors millions over a nearly two-year period, with the top earner getting more than $350,000.

PBMs don't always help

To rein in drug costs, Medicare contracts with pharmacy benefit managers (PBMs), which are supposed to negotiate down the price of drugs. Unfortunately, the city manager of Rockford says the PBM the city was using didn't do that.

He said that PBMs actually wield a lot of clout, but often don't use it when they should.

Many observers say that PBMs have divided loyalties and make money when drugs are more expensive. Express Scripts, the largest PBM in the country, for example, not only is a PBM, but it also owns a pharmacy that sells expensive drugs and a company that ships and packs them.

Rockford has sued the manufacturer of the drug and also Express Scripts, which the city hired specifically to contain costs, but alleges it didn't do.

Express Scripts has denied any wrongdoing and, in its motion to dismiss, argues it was not "contractually obligated" to contain costs.

Unfortunately, there are many players with their hand in the drug pie. Besides the drugmakers, PBMs and pharmacies, doctors can make more money by prescribing more expensive drugs over ones that are cheaper and just as effective. ❖

Employee Benefits

Telemedicine Improves Outcomes, Saves Money

RECENT STUDIES have shown that telemedicine can yield significant savings for group health plans and covered employees – but only if the employees actually use it.

While telemedicine is common among large employers (96% say they make it available to their employees), 20% of them say that less than one-tenth of their workers actually use it.

The main thrust of telemedicine is to give workers the option to talk to a health care provider over the phone or by video link about a health issue they may be having.

Maybe waiting for an appointment slot to open with their doctor would take too long, or perhaps driving to the doctor's office may be unfeasible for whatever reason.

Telemedicine can also help employees save money by avoiding copays and other fees. It can reduce the likelihood that an illness is left untreated, growing worse and more costly to treat later.

Addressing concerns

Many people are uneasy about working with a provider over a VDO link if they have had no prior patient relationship with them.

You can address these concerns by:

- Highlighting credentials of doctors in the telemedicine network.
- Working with your broker or health insurers to try to change plan designs in order to eliminate copays for telemedicine.
- Setting aside a room at your offices where your staff can access telehealth services, particularly if they have chronic conditions that may need monitoring on a regular basis.
- Choosing the right vendor, which is crucial. Evaluate vendors based on patient satisfaction, the quality of the providers and the breadth of specialties available. ❖

Telemedicine benefits

Convenience – It's often hard to take time out of the day to go to the doctor. For non-serious cases, telemedicine is a good option. If the physician or nurse feels that symptoms are serious, they can always ask the covered individual to come in for an appointment.

Cost savings – Telemedicine can save money, particularly for individuals who habitually go to ER or urgent care for routine services.

Managing chronic illness – Telemedicine is ideal for employees with chronic conditions who may have a hard time getting to regular doctors' appointments. Technology exists that can transmit health data from a patient's home to a doctor's office.

A telemedicine success story

In 2017, the National Rural Electric Cooperative Association in Virginia began offering telemedicine services to its workers, starting with a pilot program for 5,000 staff who volunteered.

With many of its employees working in the field, the power company aimed to replace urgent care visits with telemedicine, as well as provide access to behavioral health counseling and chronic-condition management.

The utility started by sending information to all of its employees and offering them a free soup mug with the provider's logo on it if they signed up. After volunteers who used the services spread the word, other employees started asking about it.

The participation rate for the pilot program in 2017 was 15%, which was well above the industry average of about 4%.

The utility saved $6 for every dollar spent. This was based on questionnaires the employees had filled out, in which many of them said they would have otherwise gone to ER or urgent care for the issues they covered during their telemedicine visit.

Due to the strong pilot program success, the NRECA this year made the program available to all of its members.

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